STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075158	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New London Sub-Acute and Nursing	90 Clark Lane Waterford, CT 06385

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policy and interviews for three (3) of seven (7) sampled residents (Residents #1, #2 and #6) who were reviewed for medication administration, the facility failed to notify the provider of medication omissions when the medications were not available. The findings include: 1. Resident #1's diagnoses included malignant neoplasm of the ovaries, schizoaffective disorder, anxiety, delusional disorders, restlessness and agitation and depressive disorder. The annual Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) of zero (0) out of fifteen (15) indicating memory recall deficits. The Resident Care Plan dated 4/28/25 identified Resident #1 received hospice services for a diagnosis of ovarian cancer. Interventions directed to administer medications per the physician's orders. a. A physician's order dated 1/11/25 directed to administer morphine sulfate oral solution 100 milligrams (mg) in 5 milliliters (mL), give 40 mg sublingually (under the tongue) every four (4) hours for pain, to be given around the clock. Review of the June 2025 Medication Administration Record (MAR) identified the morphine sulfate was not administered from 6/5/25 at 8:00 AM through 6/9/25 at 12:00 PM therefore twenty-six (26) doses were omitted. Upon further review, doses were not administered on 6/25/25 at 8:00 PM and 6/26/25 at 8:00 AM. The nurse's electronic MAR (eMAR) notes dated 6/5/25 through 6/9/25 identified the morphine sulfate was not administered because the medication was not available and was on order, the notes failed to identify a provider was notified. b. A physician's order dated 6/26/25 directed to administer morphine sulfate oral solution 100 mg in 5 mL, give 1.5 mL sublingually every four (4) hours as needed for pain and start morphine sulfate Extended Release (ER) 60 mg tablet, give two (2) tablets (120 mg) by mouth every twelve (12) hours for pain. Review of the June and July 2025 MAR identified the morphine sulfate ER 120 mg was not administered from 6/26/25 12:00 PM when it was ordered through 7/4/25 when it was discontinued, Resident #1 had gone without the scheduled pain control, a total of sixteen (16) doses and the as needed morphine sulfate oral solution was not administered in it's place. The nurse's eMAR notes dated 6/26/25 through 7/1/25 identified the morphine sulfate ER tablets were not administered because they were not available and on order, however the notes failed to reflect documentation the provider was notified. c. A physician's order dated 2/24/25 directed to administer lorazepam intensol oral concentrate 2 mg per mL, give 4 mg by mouth every four (4) hours for agitation and/or pain. Review of the MAR with associated eMAR notes from May through July 2025 identified the lorazepam was not administered ten (10) times in May 2025, thirteen (13) times in June 2025 and twenty-three (23) times in July 2025, as the medication was unavailable, on order or the resident was sleeping. The May 2025 MAR identified that from 4:00 PM on 5/22/25 through 4:00 AM on 5/24/25 there were ten (10) doses of lorazepam oral contrate not administered. Review of nurse's notes from 5/22/25 through 5/25/25 failed to reflect documentation that the charge nurses informed the nursing supervisors, and the supervisors informed the provider. The June 2025 MAR identified that from 8:00 AM on 6/2/25 until 4:00 AM on 6/3/25 there were six (6) doses of lorazepam not administered, on 6/15/25 from 12:00 PM through 12:00 AM on 6/16/25 four (4) doses were not administered and on 6/18/25 through 6/19/25 there were four (4) doses not administered because the medication was on order. Review of the Controlled Drug Record dated 6/16/25 identified 150 mL (12.5 day supply) of lorazepam was delivered to and signed for by the facility on 6/16/25, so Resident #1 should have received the lorazepam on 6/18/25 and 6/19/25 as ordered. Review of nurse's notes from 6/1/25 through 6/20/25 failed to reflect documentation that the charge nurses informed the nursing supervisors, and the supervisors informed the provider. The July 2025 MAR identified that from 12:00 PM on 7/5/25 until 4:00 PM on 7/7/25 there were thirteen (13) doses of lorazepam not administered, and twelve (12) doses not administered from 4:00 PM on 7/26/25 until 4:00 PM on 7/28/25. Review of the nurse's notes from 7/4/25 through 7/29/25 failed to reflect documentation that the charge nurses informed the nursing supervisors, and the supervisors informed the provider. The nurse's note dated 7/7/25 at 12:16 PM, after not receiving the lorazepam for two (2) days, thirteen (13) doses omitted identified Resident #1 was crying and had increased anxiety and the lorazepam was on order. On 7/7/25 at 11:43 PM Resident #1 was crying and calling out and on 7/8/25 at 1:31 PM Resident #1 was noted with increased anxiety (last doses withheld/missed 7/5/25 to 7/7/25). The Advanced Practice Registered Nurse (APRN) note dated 7/7/25 identified she had been notified on 7/7/25 that Resident #1's morphine sulfate ER tablets and lorazepam intensol oral concentrate had not arrived from either the facility's pharmacy or the hospice pharmacy

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, observations, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #3) who were reviewed for an allegation of physical abuse, the facility failed to ensure the resident was supervised when ambulating within the facility per the plan of care to prevent a resident-to-resident altercation. The findings include:Resident #3's diagnoses included Alzheimer's disease, history of falls, muscle weakness, delusional disorder, anxiety disorder and major depressive disorder. The significant change Minimum Data Set assessment dated [DATE] identified Resident #3 had a Brief Interview for Mental Status (BIMS) of four (4) out of fifteen (15) indicating poor memory recall, required moderate assistance for bed mobility and supervision assistance with transfers and ambulating. The Resident Care Plan (RCP) dated 5/30/25 identified that Resident #3 has limited physical mobility related to Alzheimer's disease and gait abnormalities. Interventions directed to provide assistance of one (1) for transfers and ambulating without a device in the facility. The nurse's note dated 7/26/25 at 10:48 AM identified Resident #3 was wandering into other residents' rooms attempting to take their walkers and was combative with attempts at redirection. The noted indicated the as needed lorazepam (anti-anxiety medication) was administered at 10:40 AM and the nursing supervisor was notified. The nurse's note dated 7/26/25 at 1:44 PM identified the nursing supervisor was called to the unit at 10:45 AM by the charge nurse, Licensed Practical Nurse (LPN) #1, as Resident #3 was observed by LPN #1 in Resident #2's room, standing over Resident #2, who was in bed, and with two (2) hands Resident #3 was attempting to place a pillow over Resident #2. The note indicated that staff immediately removed the pillow from Resident #3's hands, escorted him/her out of the room and back into his/her own room, Resident #3 was immediately placed on one-to-one observation, and the psychiatric provider and the Director of Nursing (DON) were notified of the incident. The note identified an order was obtained to transfer Resident #3 to the Emergency Department (ED) for evaluation. Interview with LPN #1 on 8/19/25 at 10:49 AM identified Resident #3 had a history of wandering into other resident rooms and could become combative with redirection. LPN #1 explained that on 7/26/25, Resident #3 had been wandering into rooms and was starting to become agitated by taking other residents' walkers, so she walked with Resident #3 to the nursing station and sat him/her down in a chair. LPN #1 identified although she knew Resident #3 required an assist of one (1) for ambulation and Resident #3 would never stay seated, there were no other staff around to assist so she left Resident #3 in the chair and went to a different hallway to her medication cart to retrieve lorazepam for Resident #3. LPN #1 identified she removed the medication out of her cart and as she approached the nursing station, she noticed Resident #3 was no longer sitting in the chair, so she went to his/her room, where a nurse aide, Nurse Aide (NA) #1, was present giving care to the roommate and reported Resident #3 had not entered the room. LPN #1 identified as she walked by Resident #2's room (next door) she observed Resident #3 standing over Resident #2 who was lying in bed and Resident #3 was holding a pillow with both hands placing in over Resident #2's face. LPN #1 identified Resident #3 did not injure Resident #2 and Resident #2 was unphased by the incident. LPN #1 indicated she removed the pillow from Resident #3's hands immediately, redirected him/her into his/her own room without incident and NA #1 stayed with Resident #3 while she notified the nursing supervisor, Registered Nurse (RN) #1. Observations of Resident #3 on 8/19/25 at 2:50 PM, identified him/her standing in Resident #8's room with no staff around the area. Resident #3 sat in a recliner chair in the room alongside Resident #8 and was noted to be calm reporting that he/she was tired and then stood and walked into the hallway, where staff redirected Resident #3 without incident. Interview with the Rehab Manager, Occupational Therapist (OT) #1, on 8/20/25 at 12:44 PM identified Resident #3 does not utilize a walker for ambulation and prior to the 7/26/25 incident, Resident #3 was to be an assist of one (1) for transfers and ambulation for safety due to fluctuating cognition. OT #1 identified that they evaluated Resident # on 8/19/25 per request of the Director of Nursing (DON) and during the evaluation Resident #1 walked into a wall, so they determined that for safety Resident #3 would remain an assist of one (1) for ambulation and was placed on Physical Therapy (PT) services. Interview with the DON on 8/20/25 at 12:50 PM identified that on 7/26/25 Resident #3 was wandering and agitated prior to the incident and LPN #1 should have waited for assistance prior to leaving Resident #3 and going to a different hallway to her medication cart. The DON identified no one saw Resident #3 get up out of the chair and enter Resident #2's room because he/she was left unattended. Review of the Preventing Resident Abuse policy dated 6/2023 directed, in part, that the facility will assess, care plan and

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on review of facility documentation, facility policy and interviews for two (2) of five (5) nurse aides reviewed for performance evaluations, the facility failed to ensure annual performance evaluations were completed. The findings include:1. NA #2 had a hire date of 7/13/23 and was due to have his/her annual performance review in 2024 and 2025, however documentation of the performance reviews was not available for review and could not be located. 2. NA #1 had a hire date of 4/30/24, had a probationary employee evaluation on 6/30/24 and was due to have his/her annual performance review on 6/30/25, however documentation of his/her performance review was not available for review in his/her personnel file and could not be located. Interview with the Administrator on 8/21/25 at 1:26 PM identified annual performance evaluations are to be done yearly but that he was unable to locate the performance evaluations for NA #1 and #2. Interview with Human Resources on 8/21/25 at 1:31 PM identified NA #1's annual performance evaluation for 2025 was due on 6/30/25 but that it had been overlooked and not completed. Human Resources identified she was unable to locate NA #2's 2024 annual performance evaluation, stating she believed it may not have been completed by the previous Director of Nursing and for 2025 she had the incorrect month documented for NA #2's hire date, so the evaluation was not completed. Human Resources identified performance evaluations are required for each nurse aide yearly on their month of hire. Review of the Certified Nurse Aide Evaluation policy directs CNAs to undergo an annual evaluation process to assess their performance, skills, and adherence to facility standards.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policy and interviews for one (1) of seven (7) sampled residents (Residents #1) reviewed for medication administration, the facility failed to follow up with the pharmacy services to ensure new medication orders were filled and standing orders were refilled prior to exhausting the supply. The findings include:Resident #1's diagnoses included malignant neoplasm of the ovaries, schizoaffective disorder, anxiety, delusional disorders, restlessness and agitation and depressive disorder. The annual Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) of zero (0) out of fifteen (15) indicating memory recall deficits. The Resident Care Plan dated 4/28/25 identified Resident #1 received hospice services for a diagnosis of ovarian cancer. Interventions directed to administer medications per the physician's orders. A physician's order dated 6/26/25 directed to administer morphine sulfate oral solution 100 mg in 5 mL, give 1.5 mL sublingually every four (4) hours as needed for pain and start morphine sulfate Extended Release (ER) 60 mg tablet, give two (2) tablets (120 mg) by mouth every twelve (12) hours for pain. Review of the June and July 2025 MAR identified the morphine sulfate ER 120 mg was not administered from 6/26/25 12:00 PM when it was ordered through 7/4/25 when it was discontinued, Resident #1 had gone without the scheduled pain control, a total of sixteen (16) doses and the as needed morphine sulfate oral solution was not administered in it's place. The nurse's eMAR notes dated 6/26/25 through 7/4/25 identified the morphine sulfate ER 120 mg was not administered because the medication was on order and not available. Interview with Person #6 (pharmacy manager) on 8/20/25 at 8:40 AM identified on 6/2/25 when the pharmacy received a script for the morphine sulfate oral solution the quantity was not identified so they called the facility for clarification but never received follow-up. Person #6 reported the facility did not reach out for an update until 6/9/25 which by that time twenty-six (26) doses had been missed and the facility authorized the pharmacy to bill for 90 mL, three (3) bottles for a sixteen (16) day supply. Person #6 explained that on 6/26/25 when the morphine sulfate ER tablets were first ordered, the pharmacy called the facility for clarification because the script was dosed incorrectly, and the facility then never called back or communicated with them until 6/30/25 when the pharmacy informed the facility communicated the dosage was on backorder and unavailable. Person #6 reported the delay in the medication getting sent to the facility was due to the facility's lack in communication and not sending scripts prior to exhausting the supply. c. A physician's order dated 2/24/25 directed to administer lorazepam intensol oral concentrate 2 mg per mL, give 4 mg by mouth every four (4) hours for agitation and/or pain. The May 2025 MAR identified that from 4:00 PM on 5/22/25 through 4:00 AM on 5/24/25 ten (10) doses of lorazepam were not administered. Review of nurse's notes from 5/22/25 through 5/25/25 failed to reflect documentation that the charge nurses informed the nursing supervisors, and the supervisors informed the provider. Interview with Person #3 (facility pharmacy representative) on 8/15/25 at 2:07 PM and review of the May 2025 MAR identified Resident #1 missed doses of lorazepam from 4:00 PM on 5/22/25 through 4:00 AM on 5/24/25. Person #3 indicated she had no documentation identifying the facility contacted them from 5/20/25 through 5/22/25 for a refill but the pharmacy did receive a new script on 5/23/25 and the pharmacy delivered the lorazepam on 5/24/25 at 3:55 AM because the facility did not request a STAT delivery. Person #3 explained she was not aware until 8/15/25, that with the 5/23/25 refill order, the pharmacy staff incorrectly calculated the amount and supply and set the next refill date to be available in eighteen (18) days when it should have been eligible for a refill in seven and one half (7.5) days. Person #3 identified the facility called on 6/2/25 to inquire about the next delivery and the facility was told the script could not be refilled until 6/11/25 so the Assistant Director of Nursing (ADON) approved a fifteen (15) day supply to be billed to the facility, which was processed and delivered on 6/3/25, however, Resident #1 missed six (6) doses of lorazepam from 6/2/25 through 6/3/25. Interview with the Director of Nursing (DON) on 8/18/25 at 1:15 PM identified the facility should not have run out of the morphine or lorazepam. The DON identified that for all doses of medication not administered, the charge nurse was to call the pharmacy to inquire on when the medication would be delivered, then notify the nursing supervisor of the missed administration so the nursing supervisor can contact the provider, and the charge nurses should be following-up with the nursing supervisor and ask if any new orders were obtained.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policy and interviews for three (3) of seven (7) sampled residents (Residents #1, #2 and #6) who were reviewed for medication administration, the facility failed to ensure the residents received scheduled anti-anxiety medication, narcotic pain medication, or both for agitation and comfort as prescribed by the physician. The failures resulted in the finding of Immediate Jeopardy. The findings include:1. Resident #1's diagnoses included malignant neoplasm of the ovaries, schizoaffective disorder, anxiety, delusional disorders, restlessness and agitation and depressive disorder. The annual Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) of zero (0) out of fifteen (15) indicating memory recall deficits. The Resident Care Plan dated 4/28/25 identified Resident #1 received hospice services for a diagnosis of ovarian cancer. Interventions directed to administer medications per the physician's orders. a. A physician's order dated 1/11/25 directed to administer morphine sulfate oral solution 100 milligrams (mg) in 5 milliliters (mL), give 40 mg sublingually (under the tongue) every four (4) hours for pain, to be given around the clock. Review of the June 2025 Medication Administration Record (MAR) identified the morphine sulfate was not administered from 6/5/25 at 8:00 AM through 6/9/25 at 12:00 PM therefore twenty-six (26) doses were omitted. Upon further review, doses were not administered on 6/25/25 at 8:00 PM and 6/26/25 at 8:00 AM. The nurse's electronic MAR (eMAR) notes dated 6/5/25 through 6/9/25 identified the morphine sulfate was not administered because the medication was not available and was on order. Both the nurse's note and eMAR note dated 6/8/25 identified Resident #1 was noted to be crying, moaning, and refused care and Tylenol (pain reliever) was administered. Review of the pain assessments from 6/7/25 to 6/9/25 identified pain levels of zero (0) through eight (8) on a scale of zero (0) to ten (10). b. A physician's order dated 6/26/25 directed to administer morphine sulfate oral solution 100 mg in 5 mL, give 1.5 mL sublingually every four (4) hours as needed for pain and start morphine sulfate Extended Release (ER) 60 mg tablet, give two (2) tablets (120 mg) by mouth every twelve (12) hours for pain. Review of the June and July 2025 MAR identified the morphine sulfate ER 120 mg was not administered from 6/26/25 12:00 PM when it was ordered until 7/4/25 when it was discontinued, Resident #1 had gone without the scheduled pain control, a total of sixteen (16) doses and the as needed morphine sulfate oral solution was not administered in it's place. Review of the pain assessments from 6/26/25 to 6/30/25 identified pain levels of zero (0) through five (5). The nurse's eMAR notes dated 6/26/25 through 7/4/25 identified the morphine sulfate ER 120 mg was not administered because the medication was on order and not available. Interview with Person #6 (pharmacy manager) on 8/20/25 at 8:40 AM identified on 6/2/25 when the pharmacy received a script for the morphine sulfate oral solution the quantity was not identified so they called the facility for clarification but never received follow-up. Person #6 reported the facility did not reach out for an update until 6/9/25 which by that time twenty-six (26) doses had been missed and the facility authorized the pharmacy to bill for 90 mL, three (3) bottles for a sixteen (16) day supply. Person #6 explained that on 6/26/25 when the morphine sulfate ER tablets were first ordered, the pharmacy called the facility for clarification because the script was dosed incorrectly, and the facility then never called back or communicated with them until 6/30/25 when the pharmacy informed the facility the dosage was on backorder and unavailable. Person #6 identified going without morphine from 6/26/25 through 7/1/25 could have caused increased discomfort, respiratory issues, pinpoint pupils, tremors, sweats, restlessness, nausea/vomiting and insomnia. Person #6 reported that the delay in the medication getting sent to the facility was due to the facility's lack in communication and not sending scripts prior to exhausting the supply. c. A physician's order dated 2/24/25 directed to administer lorazepam intensol oral concentrate 2 mg per mL, give 4 mg by mouth every four (4) hours for agitation and/or pain. Review of the MAR with associated eMAR notes from May through July 2025 identified the lorazepam was not administered ten (10) times in May 2025, thirteen (13) times in June 2025 and twenty-three (23) times in July 2025, as the medication was unavailable, on order or the resident was sleeping. The May 2025 MAR identified that from 4:00 PM on 5/22/25 through 4:00 AM on 5/24/25 there were ten (10) doses of lorazepam oral contrate not administered. Review of nurse's notes from 5/22/25 through 5/25/25 failed to reflect documentation that the charge nurses informed the nursing supervisors, and the supervisors informed the provider. The June 2025 MAR identified that from 8:00 AM on 6/2/25 until 4:00 AM on 6/3/25 there were six (6) doses of lorazepam not administered, on 6/15/25 from 12:00 PM through 12:00 AM on 6/16/25 four (4)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on clinical record reviews, facility documentation, facility policies, and interviews, the facility failed to ensure the facility administered its resources effectively and to ensure effective administrative oversight of staff and resident care to maintain the highest practicable physical, mental and psychosocial well-being of residents. The findings include:The facility administration failed to: Ensure continued compliance with the plan of correction from a prior survey to ensure medications were administered per physician's orders. Ensure the residents were administered scheduled anxiety and narcotic pain medications. Ensure medications were refilled prior to exhausting the supply and ensure medications were delivered to the facility. Ensure the Advanced Practice Registered Nurse (APRN) was notified of medication omissions. Ensure annual performance evaluations were completed when due. Ensure the clinical record was complete and accurate. Please cross reference F580, F730, F755, F760, F842 and F865. Based on the deficiencies during the survey, immediate jeopardy and substandard care was identified in the area of Pharmacy Services-Residents Are Free of Significant Medication Errors. The State Agency conducted a survey with an exit date of 6/30/25 with findings of significant medication errors. The Plan of Correction identified the facility would conduct staff education, audits and QAPI to ensure all nursing staff are administering medications according to provider orders and notifying the Registered Nurse (RN) supervisor and provider when medications were administered late, with a correction date of 7/31/25. Interview with the Administrator, Director of Nursing and RN #6 (the Corporate Regional Nurse) on 8/21/25 at 1:28 PM identified although the facility was cited for medication related errors on both their annual survey dated 3/27/25 and most recently, significant medications errors on 6/30/25 for failing to ensure medications were administered at the time the medications were due and failing to notify the nursing supervisor or the provider of the late medication administrations, they were not put back into compliance with their 6/30/25 survey findings as of 8/20/25, as it was identified medications continued to be administered late to residents. Interview failed to identify the facility was able to sustain compliance with the previously cited findings and failed to identify a process for administrative oversight of the facility processes for ensuring timely medication refills, ensuring medications are administered timely and ensuring that providers are notified of missed medication administrations. Review of the Administrator Job Description identified the responsibility of the Administrator was to plan, organize, develop, direct, control and supervise the overall operations of the facility in accordance with current federal, state, and local laws, regulations, standards and guidelines, and to ensure the highest degree of quality resident life is maintained.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075158	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New London Sub-Acute and Nursing	90 Clark Lane Waterford, CT 06385

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policy and interviews for two (2) of three (3) sampled residents (Residents #1 and #2) reviewed for medication administration, the facility failed to ensure complete and accurate documentation of medications in the Medication Administration Record (MAR). The findings include:1. Resident #1's diagnoses included malignant neoplasm of the ovaries, schizoaffective disorder, anxiety, delusional disorders, restlessness and agitation and depressive disorder. The annual Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) of zero (0) out of fifteen (15) indicating memory recall deficits. The Resident Care Plan dated 4/28/25 identified Resident #1 received hospice services for a diagnosis of ovarian cancer. Interventions directed to administer medications per the physician's orders. a. A physician's order dated 1/11/25 directed to administer morphine sulfate oral solution 100 milligrams (mg) in 5 milliliters (mL), give 40 mg sublingually (under the tongue) every four (4) hours for pain, to be given around the clock. Review of the June 2025 MAR identified although the morphine sulfate oral solution was signed off as administered on 6/5/25 at 4:00 PM, it had previously been signed off as unavailable and on order for both the 8:00 AM and 12:00 PM doses on 6/5/25 and was signed off as unavailable from 8:00 PM on 6/5/25 through 12:00 PM on 6/9/25. The MAR identified the morphine sulfate was signed off as administered at 12:00 AM and 4:00 AM on 6/26/25, when it had previously been signed off as unavailable and on order since 8:00 PM on 6/25/25. Review of the morphine sulfate Controlled Drug Record disposition sheets failed to identify the morphine sulfate was signed out at 4:00 PM on 6/5/25, at 8:00 AM on 6/7/25, and at 12:00 AM and 4:00 AM on 6/26/25. Interview with the charge nurse, Licensed Practical Nurse (LPN) #2, on 8/18/25 at 9:48 AM identified that if she did not sign the morphine sulfate out on the Controlled Drug Record disposition sheet on 6/5/25 at 4:00 PM she must have clicked off the administer button in error. The MAR identified the morphine sulfate was signed off as administered on 6/7/25 at 8:00 AM, when it had previously been signed off as unavailable and on order for more than twenty-four (24) hours prior to the 6/7/25 administration and more than twenty-four (24) hours after the 6/7/25 administration. b. A physician's order dated 2/24/25 directed to administer lorazepam intensol oral concentrate 2 mg per mL, give 4 mg by mouth every four (4) hours for agitation and/or pain. Review of the May 2025 MAR identified that although the lorazepam was signed off as administered on 5/23/25 at 4:00 PM, it had previously been signed off as unavailable and on order since 4:00 PM on 5/22/25 and was signed off as unavailable from 8:00 PM on 5/23/25 through 4:00 AM on 5/24/25. Review of the lorazepam Controlled Drug Record disposition sheets failed to identify the lorazepam was signed out at 4:00 PM on 5/23/25. Review of the June 2025 MAR identified although the lorazepam was signed off as not administered by LPN #8, reporting it was on order on 6/18/25 at 4:00 PM through 6/19/25 at 4:00 AM, four (4) doses, the lorazepam had been signed off as administered on 6/18/25 at 12:00 PM and on 6/19/25 at 8:00 AM. Review of the lorazepam Controlled Drug Record disposition sheets identified 150 milliliters (mL)/5 bottles, a twelve and one half (12.5) day supply had been delivered on 6/16/25. Review of the July 2025 MAR for identified although the lorazepam was signed off as administered on 7/6/25 at 4:00 PM, the lorazepam had previously been signed off as unavailable and on order since 4:00 PM on 7/5/25 and was signed off as unavailable until 7/8/25 at 8:00 AM. Review of the lorazepam Controlled Drug Record disposition sheets failed to identify that the lorazepam was signed out at 4:00 PM on 7/6/25. Interview with LPN #2 on 8/18/25 at 9:48 AM identified that if she did not sign the lorazepam out on the Controlled Drug Record disposition sheet on 7/5/25 at 4:00 PM she must have clicked off the administer button in error. 2. Resident #2's diagnoses included dementia with behavioral and mood disturbances and anxiety disorder. The Resident Care Plan dated 7/30/25 identified that Resident #2 utilized psychotropic medications related to diagnoses of adjustment disorder, depression, anxiety, Alzheimer's dementia, delusional disorder and mood disorder. Interventions directed to administer psychotropic medications as ordered by the physician and monitor for side effects and effectiveness every shift. A physician's order dated 8/5/25 directed to administer lorazepam oral concentrate 2 mg per mL, give 0.5 mL by mouth three (3) times daily for anxiety/agitation/irritability. Review of the 2025 August MAR identified that the 8/5/25 at 12:00 PM administration of the lorazepam was blank and not signed off. Although requested a Controlled Drug Record disposition sheet for the lorazepam was not available. Interview with LPN #1 on 8/19/25 at 10:49 AM identified that she forgot to sign off the lorazepam as not administered on 8/5/25 at 12:00 PM, reporting that she should have checked the clinical record before leaving for her shift to ensure

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. Based on review of facility documentation, facility policies, and interviews for facility QAPI review, the facility failed to maintain compliance with deficiencies previously cited. The findings include:A complaint survey was completed on 6/30/25 with findings related to significant medication errors and failures in notifying the provider. The facility Plan of Correction (PoC) identified audits would be conducted for three (3) months or until substantial compliance with QAPI oversight. Resident record review identified three (3) residents (Residents #1, 2 and 6) who were not administered scheduled medications, and the provider was not notified of the missed administrations. Resident record review identified three (3) residents (Residents #4, #6 and #15) who were administered scheduled medications late and the provider was not notified of the late administrations. Review of the 7/16/25 QAPI meeting identified the meeting included a review of the 6/30/25 survey results, including medication pass timeliness and noted that audits were ongoing and showed ongoing compliance improvement. A facility re-visit on 8/20/25 for the 6/30/25 findings identified the facility failed to ensure medications were administered and was unable to be put back into compliance. The Director of Nursing identified on 8/20/25 at 3:25 PM while the facility had been completing chart audits for late medication administrations since 6/27/25, she was unaware that late medication administrations were still ongoing this information was not captured on their audits. Review of facility documentation identified the following late medication administrations during the PoC: 7/13/25, 7/17/25, 7/26/25, Resident #6Review of facility documentation identified the following late medication administrations after the PoC: 8/2/25, Resident #4 8/2/25, 8/18/25, Resident #6 8/4/25, 8/11/25, 8/13/25, Resident #15Review of facility documentation identified the following omitted medication administrations during the PoC: 6/30/25 through 7/9/25, 7/26/25, 7/27/25, 7/28/25, Resident #1 7/21/25 through 7/24/25, Resident #6Review of facility documentation identified the following omitted medication administrations after the PoC: 8/5/25 through 8/8/25, Resident #2 Interview and facility documentation review with the Administrator on 8/21/25 at 1:28 PM identified although they were conducting audits for medication administrations, they were random resident audits, and they did not identify that both late and omitted medication administrations were ongoing, and he was unable to explain why. The Administrator was unable to identify why their previous 6/30/25 PoC was ineffective and reported that they will be developing new processes and upcoming audits will be increased to daily to be done by multiple staff. Please cross reference F580 and F760. Review of the Quality Assurance Improvement Plan (QAPI) policy dated 4/2025 directed, in part, that the Administrator and DNS are responsible and accountable for developing, leading and closely monitoring the QAPI program and assures the facility has adequate resources for QAPI efforts.